

The purpose of questions listed below is to secure complete information regarding the condition of the applicant's health. All diseases, injuries, abnormalities, deformities, or infirmities must be stated and fully described. Statements made by the applicant in this application are relied upon in granting insurance. Consequently, any deception or knowingly false statement either by inference, omission, or otherwise may result in cancellation of the insurance or in the refusal to pay a claim on the policy.

It may be necessary to ask for a physical examination in connection with this application.

Please answer every question, date and sign this application.

NOTE: Complete the following employment questions. If additional space is needed, attach a separate sheet of paper.

1A. ARE YOU NOW WORKING?

☐ YES ☐ NO

1C. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY

1B. DO YOU WORK FULL TIME?

☐ YES ☐ NO

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING: (Check all that apply)

	YES	NO		YES	NO
2. DISEASE OF THE HEART OR ARTERIES; CHEST PAIN?			14. ANY DISEASE OF THE PROSTATE OR TESTES IF A MALE; UTERUS, OVARIES OR BREAST IS A FEMALE?		
3. HIGH BLOOD PRESSURE?			15. DO YOU USE OR HAVE YOU BEEN TREATED FOR THE USE OF ALCOHOL OR ANY HABIT FORMING DRUG?		
4. CANCER, TUMOR OR POLYP?			16. WITHIN THE PAST 5 YEARS, HAVE YOU BEEN TREATED BY A PHYSICIAN?		
5. LUNG DISEASE?			17. ARE YOU NOW OR HAVE YOU EVER BEEN HOSPITALIZED FOR ILLNESS, DISEASE OR INJURY?		
6. EPILEPSY, UNCONSCIOUSNESS, DIZZINESS OR IMPAIRMENT OF NERVOUS SYSTEM?			18. DO YOU HAVE ANY SERVICE CONNECTED DISABILITIES?		
7. EMOTIONAL OR MENTAL DISORDER?			19. HAVE YOU EVER APPLIED FOR DISABILITY COMPENSATION OR PENSION?		
8. DISEASE OF THE BLOOD?			20. HAS ANY APPLICATION YOU HAVE MADE FOR PRIVATE OR GOVERNMENT LIFE, HEALTH, DISABILITY OR ACCIDENT INSURANCE BEEN REFUSED, POSTPONED APPROVED AT SUB-STANDARD RATES OR ON A DIFFERENT BASIS THAN APPLIED FOR?		
9. TUBERCULOSIS, PLEURISY, OR BRONCHITIS?			21. HEIGHT: FEET INCHES		
10. DIABETES?			22. WEIGHT: POUNDS		
11. ARTHRITIS, PARALYSIS, OR DISEASE, OR DEFORMITY OF THE BONES, MUSCLES, OR JOINTS?					
12. DISEASE OR ULCER OF STOMACH, INTESTINES OR RECTUM?					
13. ANY DISEASE OF THE URINARY TRACT, SUGAR, ALBUMIN, OR BLOOD IN URINE?					

23. REMARKS (Give complete details to "YES" answers. Include dates, diagnosis, physicians or hospitals, and names and addresses. Indicate after each disability whether service-connected nonservice-connected. If additional space is needed, attach a separate sheet of paper)

I consent that any hospital, physician or surgeon who has treated or examined me for any purpose, or whom I have consulted professionally may divulge to VA any information obtained by them, or it, concerning myself. I understand that the Government will rely on the truth of these answers. I HAVE READ THE ABOVE ANSWERS AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE.

I am obliged to advise VA of any change of health condition arising after the signing and prior to delivery of this form to VA.

24A. SIGNATURE

24B. DATE